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# USAID/MOZAMBIQUE MIDTERM EVALUATION OF STRATEGIC OBJECTIVE 8 PROVINCIAL/ DISTRICT/COMMUNITY-LEVEL ACTIVITIES

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# USAID/MOZAMBIQUE MIDTERM EVALUATION OF STRATEGIC OBJECTIVE 8 (SO8) PROVINCIAL/DISTRICT/ COMMUNITY-LEVEL ACTIVITIES

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## ACRONYMS

AIDS	acquired immune deficiency syndrome
CA	cooperative agreement
CH/RH	child health and reproductive health
CHA	community health agent
CHC	community health council
CLC	community leadership council
CLCH	community leadership council for health
COACH	Community Access to Health Services Project
COPE	client-oriented, provider-efficient services
CS	child survival
DHA	district health authority
DHD	district health directorate
FP	family planning
GH Tech	The Global Health Technical Assistance Project
HIV	human immunodeficiency virus
HMIS	health management information system
HSDS	Health Services Delivery and Support Project
IEC	information, education, and communication
IMCI	integrated management of childhood illness
ITN	insecticide-treated net
KAP	knowledge, attitude, and practice
MCH	maternal and child health
MOH	Ministry of Health, Mozambique
MoU	memorandum of understanding
NGO	nongovernmental organization
PHA	provincial health authority
PHD	provincial health directorate
PLA	participatory learning and action
PVO	private voluntary organization
RH	reproductive health
SO	strategic objective
SOW	scope of work
STI	sexually transmitted infection
SUFORS	supervisors/trainers
SWAp	sector-wide approach
TBA	traditional birth attendant
UN	United Nations
USAID	U.S. Agency for International Development
WV	World Vision

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# EXECUTIVE SUMMARY

## BACKGROUND

The health team (SO8) of the U.S. Agency for International Development in Mozambique (USAID/Mozambique) requested that the Global Health Technical Assistance Project (GH Tech) conduct an external midterm evaluation of its activities relating to maternal, child, and reproductive health. The evaluation was to include—but not be limited to—an assessment of USAID’s participation in the improvement of Mozambicans’ health addressed in cooperative agreements (CAs) the Agency signed in the first quarter of 2005 with four private voluntary organizations (PVOs). The CAs encompass PVO work in four Mozambican provinces: Gaza (Project Hope’s Project Lissima), Maputo (Pathfinder’s Project Mahiça), Nampula (Save the Children’s Project OKUMI), and Zambézia (World Visions’ Project COACH).

Two GH Tech consultants conducted the midterm evaluation from October 6 to November 8, 2006. USAID/Mozambique will use the results to make informed adjustments to the current PVO agreements and, possibly, adjust how provincial-level and community-level support is implemented.

USAID/Mozambique is supporting the Mozambican Government in its efforts to improve the health status and related health indicators of the country’s population, within the framework of a health sector-wide approach (SWAp). This support assists the Mozambique Ministry of Health (MOH) to strengthen and develop customer-focused, quality-driven, child health and reproductive health (CH/RH) services.

A key premise in designing and implementing the CAs is that “quality is an integral element of access to health services,” and that “clients need to understand value and seek out quality services” is an important consideration. In addition, to implement the CAs, the PVOs are charged with strengthening the government’s decentralization process through the improvement of the management capacity of provincial health directorates (PHDs) and district health directorates (DHDs).

The evaluation employed a qualitative methodology and multiple sources of evidence. Evaluators reviewed selected publications and internal documents of the PVOs and engaged in-depth interviews and group discussions with stakeholders.

## MAJOR EVALUATION FINDINGS

All four projects suffered delays of between six and nine months in mobilization and startup. However, all four projects are now accomplishing results that increase the use of child survival (CS) and reproductive health (RH) services and the adoption of key health practices, although at varying paces and degrees and at levels lower than anticipated. To achieve the reported results, PVOs spent between 30 percent (Project Hope) and 51 percent (Pathfinder) of their budgets.

As USAID intended, all projects focused more on community-level activities and community development than on institutional-level activities. Improving the community’s health status seemed to interest most of the community leadership councils (CLCs) and local populations. However, community empowerment to resolve health problems remains an ongoing process for most projects.

None of the projects has an activity-based management accounting system in place, which increases the possibility that activity costs are underestimated.

Because field staff of most projects have limited managerial and data management expertise, skill transfer usually does not occur during contacts at health facility and district directorate levels.

The four projects enjoy good relationships with local health authorities, who perceive them as assets that complement their capacity within the framework of co-designed work plans. However, working in partnership with official health structures at district and provincial levels often complicated the projects' compliance with timelines, reporting obligations, and achievement of targets.

## CONCLUSIONS

### Lessons Learned

The following lessons may be drawn from the midterm evaluation findings:

- The collaboration between the projects, the MOH, CLCs, and other partners resulted in a holistic approach to improving CS and RH in the provinces.
- The projects complement local government resources and infrastructure; they are crucial to the implementation of community-level interventions.
- It is important for government, communities, and projects to jointly plan, implement, monitor, and evaluate activities to assure successful implementation and sustainability of desired behavior changes.
- Working through and with the formal health official structures at district and provincial levels is perceived as a commendable and appropriate approach, one that promotes and facilitates the sustainable development of institutions and communities and reinforces government efforts to improve and strengthen official structures, processes, and procedures. However, the high level of interface with health officials requires project staff to have appropriate and culturally sensitive interpersonal communication skills.
- The Government of Mozambique recognizes the value of nongovernmental organizations (NGOs) in implementing these projects.
- Meaningful transfer of skills to local institutions has occurred only when project staff are well prepared and knowledgeable.
- The projects' achievement of outcome targets is problematic, since their design and approach include only selected communities (not all communities in the target area), and interventions are limited in time and scope.
- Services need be available and physically accessible for their use to increase in the short-run.
- The cost-effectiveness of the projects is difficult to assess, since no activity-based costing is in place and most implementation costs are embedded in non-reported activities. Furthermore, much of the outcome data available are outside project control and often unreliable. Finally, major differences in management and structure make it impossible to infer whether performance and outcomes are related to the size of each project's target population. With this caveat, this evaluation reached no conclusions about cost-efficiency that could be attributed directly to this factor.

### Major Recommendations

*At the institutional level*, service provision should be strengthened by initiating quality assurance activities, including supportive supervision and constant availability of essential drugs, contraceptives, and vaccines; as well as the availability of information, education, and communication (IEC) materials. Improvements to some health facilities are required, including for their buildings and water and power supplies. To achieve USAID's strategic objectives (SOs), the projects need to make services available to remote populations by increasing their support for outreach health activities. Concomitantly, the projects should provide technical assistance and

increase the transfer of skills at provincial, district, and facility levels for strategic planning and data management and use, in accordance with perceived needs and joint planning.

***At the community level,*** health services use should be strongly promoted and facilitated, and linkages between the community and the health facility actively developed. Community empowerment should be pursued, but following necessary steps and timing. In addition, projects should encourage and facilitate community income-generating activities and pursue multisectoral synergic activities.

***In the future,*** it is recommended that USAID avoid creating an implementation or service delivery gap in project activities that would cause an interruption in progress toward sustainability. Sustainable development should be approached comprehensively to include multisectoral synergic activities and projects that promote economic growth in communities. The principles of the present approach are perceived as commendable, but project implementation on the ground needs adjustments to avoid large delays in the startup phase and increase cost-effectiveness. In this vein, upfront agreement on project design between the projects and the MOH and its local structures is recommended. Main activities should be included in the workplan. It is also recommended that NGOs are left with some latitude to approach interventions and pursue targets with some creativity.

# I. INTRODUCTION

## PURPOSE

The health team (SO8) of the U. S. Agency for International Development in Mozambique (USAID/Mozambique) requested that the GH Tech conduct an external midterm evaluation of its provincial, district, and community-level activities to include (but not be limited to) an assessment of USAID's participation in the improvement of Mozambicans' health through the work of four PVOs in the provinces of Gaza, Maputo, Nampula, and Zambézia, as detailed in USAID cooperative agreements (CAs) signed in the first quarter of 2005.

The objectives of the evaluation were stated as follows:

1. evaluate the performance of four PVOs and their subgrantees in
  - a. *delivering quality maternal and child health services*, in relation to aims set forth in the
  - b. *transferring skills and building capacity* of provincial health departments in delivering quality maternal and child health services
2. assess this model of USAID support to provincial health departments in light of the current and expected context over the next five years, and in relation to other models of donor support for local and community health in Mozambique and other countries with similar conditions
3. provide recommendations for the extension and/or revision of the CAs, as well as recommendations for alternative implementing mechanisms, if applicable.

## BACKGROUND

Although infant, child, and maternal mortality rates in Mozambique have been decreasing in recent years, they are still among the highest in Africa and the world. USAID's SO8 aims to contribute to the reduction of these high mortality rates. While the Government of Mozambique is committed to building an equitable health system that is affordable and sustainable, the health infrastructure, provision of services, and networks are not sufficiently developed to meet the health needs of a highly dispersed population, resulting in poor quality healthcare.

Over 41 percent of children under 5 were observed with chronic malnutrition, 4 percent from acute malnutrition; 23.7 percent of children showed low weight-for-age, and only 65 percent of children 12–23 months were fully immunized. Malaria is the primary cause of mortality in Mozambique; it accounts for roughly 15 percent of the country's total disease burden and 39 percent of deaths among infants and young children. Compared to other African countries, Mozambique's infant mortality and under 5 mortality rates are high, at 124 and 178 deaths per 1,000 live births, respectively. Of USAID's four targeted provinces, Nampula has the highest rates of infant and child deaths.

The use of antenatal services in Mozambique is relatively high (84.6 percent in 2003 data), although less than half of deliveries were assisted by a trained health worker. Lack of access to skilled birth attendants and inadequate referral and evacuation for more qualified obstetric care are generally considered to be among the most important factors that contribute to the country's high maternal mortality rate of 408 deaths per 100,000 births.

Two aspects of the present context of USAID/Mozambique's support to the health sector should be mentioned. First, the U.S. Government, as a major donor signing the Paris Declaration on Donor Aid Harmonization in 2005, is among a larger group of donors whose funds are provided with synergic objectives. Second, both the Mozambican Government and donors recently adopted a health sector-wide approach (SWAp) for funding purposes and mechanisms. USAID is a

member of the health SWAp but, rather than contributing financially to the common fund, it provides support to the MOH to help strengthen and develop customer-focused, quality-driven service delivery at the facility level relating to maternal and child health and reproductive health (MCH/RH).

This new environment in Mozambique has resulted in the need for USAID to adapt its health programming, focus more on the desire for greater national self-reliance, and be mindful of the growing debate about the appropriate role of external technical assistance and NGOs in the health sector. There is now heightened concern about how donors should align their planning, as well as about the monitoring and evaluation of the use of external funds and, ultimately, their impact in the health and life of the population.

To contribute to the reduction of Mozambique's high mortality rates, a key premise of the design and implementation of the CAs was that "quality is an integral element of access to health services" (see annex A). Consequently, "health services need to meet a minimum quality standard before they are deemed to be available." Concomitantly, "clients need to understand value and seek out quality services."

USAID believes that by guaranteeing efficient logistics and supplies, adequate referral systems, and effective supervision, its projects "would stimulate communities to seek out and successfully use health services and health information and subsequently achieve improved health status."

In addition, while implementing and pursuing their specific contractual objectives, the PVOs have had an additional—indirect, but no less important—goal: the strengthening of the government's decentralization process through the improvement of the managerial capacity of provincial and district health directors and their departmental staff.

### The Cooperative Agreements

To provide support to the Mozambican Government, USAID signed four CAs in the first quarter of 2005 for the implementation of projects summarized in table 1.

Table 1. The four projects included in the midterm evaluation				
Organization/ Project	PATHFINDER Project Manhiça	PROJECT HOPE Project Lissima	SAVE THE CHILDREN Project OKUMI	WORLD VISION Project COACH
Province	Maputo	Gaza	Nampula	Zambézia
Life of Project	February 1, 2005, to January 31, 2008	April 1, 2005, to March 31, 2008	February 7, 2005, to January 31, 2008	February 1, 2005, to January 31, 2008
Total US\$ <sup>1</sup>	1,499,945	2,099,958	5,700,000	5,699,999
Target Population <sup>2</sup>	141,171	910,890	3,100,000	3,328,452

<sup>1</sup> This is the total USD amount; it does not include matching funds.

<sup>2</sup> Population figures were supplied by project managers.

The projects were proposed to USAID/Mozambique in response to its annual program statement of August 2004. A condition for the Agency's acceptance of the project proposals was their contribution to the achievement of the following SO:

**Increased use of CS and RH services in target areas**

1. assessed through the following indicators:
  - a. percentage of children receiving vitamin A supplementation
  - b. percentage of children fully immunized
  - c. percentage of women using modern contraception
  - d. percentage of households in pilot districts using insecticide-treated nets (ITNs)
  - e. percentage of assisted deliveries
2. achieved through the following programmatic results:
  - a. increased access to quality CS/RH services by
    - i. strengthening primary health services at the facility level
    - ii. establishing and expanding community health services
  - b. increased community demand for quality CS/RH services through
    - i. improvement of peoples' health knowledge and attitudes
    - ii. increased community awareness of available services

In addition, a particular emphasis was put on the projects working with and in support of the Mozambican provincial and district health structures and within the guidelines of the MOH—its processes, procedures, and strategy for community participation.

The four CAs assessed by this midterm evaluation are with Pathfinder, Project Hope, Save the Children, and World Vision.

**OVERVIEW OF THE ASSIGNMENT: METHODOLOGICAL APPROACH**

The methodology employed responds to USAID/Mozambique's purpose of using the midterm evaluation to review the performance of each project against its contractual targets, and also to make informed adjustments to current PVO funding awards or adjust program implementation of provincial, district, and community-level support.

The field assessment used multiple sources of evidence to gain a comprehensive and deep understanding of complex, diverse, and multiple phenomena involved in the implementation of these projects; to decrease the errors implicit in any chosen, single assessment method as well as those arising from the researchers' own basic assumptions and past experiences; to interpret findings adequately; and to arrive at the correct conclusions and make accurate inferences.

Sources of data and information included the PVO websites, internal documents, the CAs, annual and quarterly reports, financial statements and other reports, databases and records, observation of participants' interactions, in-depth interviews, group discussions, and a questionnaire (see annexes B and C). Subsequently, findings and primary conclusions were discussed with selected managers of each PVO and their partners and stakeholders, USAID's SO8 team, and, lastly, with MOH officials. Finally, the case study findings, conclusions, and lessons learned were reported and recommendations developed.

The approach included the following:

- ***Review of relevant literature.*** Many publications were consulted and reviewed to obtain a comprehensive and holistic understanding of the economic, legal, social, and health situation in Mozambique and the environment in which USAID and PVOs operate. Annex D contains an annotated list of the documents collected and reviewed.
- ***Design and preparation of the field assessment.*** An agenda and protocol were developed and instruments prepared in Maputo before the evaluators departed for the provinces.
- ***Field assessment.*** The evaluation team spent approximately four days visiting each project site and three to four additional days reviewing project documents and meeting with managers. Four districts were visited in Nampula and Zambézia. Two districts were visited in Gaza, and the sole project district in Maputo was visited. In each province, provincial health directors or medical officers-in-chief were interviewed, as were the district directors and the district MCH chief nurse. In each district visited, several health facilities were briefly assessed and health staff interviewed. Several communities in each district were also visited, and group discussions were held with different community groups, community leaders, and volunteers. Most supervisors, middle managers, and top managers from each project were interviewed and asked to respond to a questionnaire.
- ***Key informant interviews.*** In addition to the interviews directly or indirectly linked to the project and its implementation, the evaluators interviewed officials of the MOH and partner organizations, such as other NGOs, the World Bank, the European Union, the SWAp coordination team, and UN agencies. These interviews enabled the evaluation team to set relevant parameters for the best approach for the implementation of health projects in Mozambique.
- ***Analysis, interpretation, and discussion of findings.*** A preliminary analysis of findings was conducted immediately after completing field visits. Additional data were then requested from all projects to confirm findings, and additional meetings were held with project management staff to discuss findings and ascertain the reliability of data. Internal discussions followed that compared the quality of data, information, and results across the different projects.
- ***Writing of the report, including conclusions and recommendations.*** This final step was completed after the evaluators left Mozambique.

## II. FINDINGS

### TECHNICAL SUMMARY

#### Results

After delays of six to nine months in mobilization and startup, all four projects are now achieving results to increase the use of CS and RH services and the adoption of key health practices, although at varying paces and degrees and lower levels than anticipated. Because of delays, none of the projects met first-year targets. Since start-up, all projects have increased their rate of performance, though only two of them (World Vision's Project COACH and Pathfinder's Project Manhiça) reached most of the midterm targets or are close to this achievement. For World Vision, this level of success is related to the length of time the NGO has been working in the province (over 10 years prior to the present project), its established relationships with provincial and district directorates, and efficient and adequately decentralized management structure. Pathfinder's Project Manhiça has a high proportion of qualified staff (four) per target population and the geographic scope of one district, thus giving it the chance to develop and implement an innovative model of sustainable development and integration with the health system that is seen as promising and meriting a meticulous follow-up of potential value-added results.

To achieve the reported results, PVOs spent between 30 percent (Lissima) and 51 percent (Manhiça) of their project budgets.

#### Focus

All projects have focused more on community-level activities and community development than on institutional-level activities, and the results reflect this focus. All communities visited by the evaluation team knew the relevant project well. Community members sang songs with various health messages on the team's arrival, and some performed health-related dramas; billboards with health messages were seen in many communities. Most community leadership councils (CLCs) seemed interested in participating in projects that improve the health of their populations.

In communities visited, most community health agents (CHAs)—volunteers trained by the project—were actively interested in the results of their work, although many referred to the limited time available for conducting their informational and educational activities and to difficulties in filling out forms required for the transfer of patients to health facilities. Notwithstanding, those interviewed expressed contentment with the project's presence and the betterment of health conditions they perceived after the initiation of its activities.

Interventions have been similar across the four projects. At the institutional level, these have included

- joint planning with provincial health directorates (PHDs) and district health directorates (DHDs)
- training of health workers from MOH
- follow-up of trainees
- support for immunization campaigns
- support for mobile brigades
- acquisition and distribution of essential equipment to institutions and/or health units

Activities at the institutional level are conducted essentially by MOH staff, with logistical and financial support of the projects. Admittedly, results achieved by most projects in the enhancement of quality care have been poor. However, to a large extent, these are dependent on MOH structures and are outside project control. The results depend not only on central strategies,

guidelines, and protocols relating to quality assurance methodologies and instruments, but also depend on provincial, technical, and human resources available to provide refresher-training courses and formative supervision.

The four PVOs are working at the central level through the intermediary actions of the USAID-funded Project Forte Saúde to develop the needed tools, guidelines, and methodology for quality assurance. In the meanwhile, Project Manhiça (Pathfinder), the only project with meaningful activities at this level and whose management expertise include ex-MOH central staff, has adapted existing tools and developed its own approach to quality assurance.

At the community level, interventions have included

- furnishing bicycles and/or bicycle ambulances (three projects)
- training, community mobilization and organization
- implementing IEC initiatives
- improving the referral system
- promoting income-generating activities (two projects)

While three of the four PVOs implemented their projects more or less simultaneously throughout targeted geographical areas, Pathfinder's Project Manhiça concentrated most of its activities in one selected area, as well as within a framework of sustainable community development and a health system integration model that uses carefully and thoroughly developed methodology.

## **Program and Management**

### **Project Management, including Tracking and Reporting**

All projects had their initial workplan proposals reviewed and adapted to respond to provincial needs and priorities. "New" project workplans have been revised annually, jointly with health authorities, and they are similarly reviewed and adjusted quarterly. All projects hold monthly meetings with district health teams to review the previous month's activities and achievements and plan activities for the following month.

For all projects, distances between communities, bad road conditions, and the overall unavailability of telecommunication have constrained the implementation of activities and the development of adequate linkages between communities and health facilities.

Since all projects have two major components—a focus on community activities and a second focus on strengthening the capacity of the government health institutions to improve service delivery—project monitoring systems track two sets of indicators. One set relate to activities at the community level, while the other set of indicators center on services delivered by health facilities. Community-level data are the sole responsibility of the PVOs, who have an active role in improving the quality of data of DHDs.

The limited strategic planning and data management expertise of field staff in project OKUMI and Lissima makes the transferring of skills rare during contacts at health facilities and district directorates. Only when these contacts involve experienced and qualified project staff does appropriate skills transfer occur.

It is important to point out that some baselines used to gauge present achievement were derived from Knowledge, Practice, Coverage (KPC) studies conducted about a year and a half before the projects began and immediately after behaviour change interventions, and other baselines were derived from vaccination and vitamin A campaigns. It is also important to note that projects are reporting process indicators against such baselines, but using data from service provided. This presents a problem, since the percentage of achievement is not comparable.

The PVOs have three main sources of data:

1. data collected from the KPC at the beginning of the projects<sup>3</sup>
2. monitoring data from the PVO community activities
3. monitoring data from the hospital information system

Currently, trend information can only be collected employing the last two sources listed. KPC data can not yet be compared because final data will not be available until mid-2008.

The recent involvement in the monitoring and evaluation processes and procedures of projects in Mozambique by USAID's new Forte Saúde project will be a relevant asset when choosing appropriate and adequate indicators and data for baseline and targets.

#### Relationship with Formal Health Structures

The four projects have good relationships with local health authorities, who perceive them as assets—responsive to their needs and complementing their capacity within the framework of co-designed workplans. The projects are developing their activities within the MOH guidelines for its processes and procedures and strategy for community participation. In all projects, original workplans and interventions were changed and adapted to respond to perceived needs and priorities of provincial health authorities.

The projects provide good support for provincial health authorities (PHA) and district health authorities (DHA). The projects complement their financial resources, particularly for outreach activities such as the mobile brigades, which mostly use the cars and/or gasoline that the projects provide. The four projects also complement MOH efforts to increase the populations' access to health services through efforts to provide them with information and education about health-related issues, particularly MCH. This level of intervention is crucial because the MOH does not have the human resources needed to perform this task.

All projects maintain very good relationships with PHAs and DHAs. However, as noted, working in partnership with official health structures at district and provincial levels can cause difficulties in complying with timelines, meeting reporting obligations, and achieving targets.

#### Relationship and Interaction/Synergism with other NGOs in the Region

While there is a general need for improving interactions between the four PVOs and other NGOs working in the region, there are notable examples of good working relationships. All projects have promoted and distributed PSI's ITNs among target populations, and World Vision also has a close working relationship with PSI to increase the use and sale of "Certeza" (water purifier). In addition, World Vision has ongoing projects in Zambézia—particularly projects relating to the education of girls and women—whose activities are synergic with Project COACH, along with other activities that indirectly and positively influence Project COACH's results, including those relating to agriculture, the development of income-generating activities, and the building and repairing of wells and other infrastructures.

### **PROJECT OKUMI, NAMPULA**

#### **Technical**

Project OKUMI is being implemented by grantee Save the Children USA and sub-grantee Care International. The end-of-project goal for OKUMI is to increase use of CS and RH services and the adoption of key health practices by about 3.1 million inhabitants who are spread throughout about 60,000 square kilometers in 14 targeted districts of Nampula province.

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<sup>3</sup> Another KPC is planned at the end of each project to allow comparison with the baseline KPC.

There was significant delay (about 9 months) in project activity startup, due mainly to serious difficulties in reaching agreement with local health authorities on the proposed workplan and the project's focus. The situation was made worse by interpersonal communication difficulties between the project manager and the health authorities. Several activities not included in the original workplan that aimed to enhance the quality of care were included in the new, approved workplan, including the acquisition of equipment, hiring of nurses, and training of basic nurses. These elements were added to OKUMI's workplan at the request of the PHD, with USAID's agreement. During the last six months, and after the hiring of a new project manager, OKUMI has made considerable progress in meeting proposed targets.

Selected activities performed by Project OKUMI at the institutional level have included

- Providing one motorcycle, one computer, and cold-chain equipment for each of the 14 districts, along with radios for nine maternity facilities.
- Providing financial support for 18-month, formal training courses in basic maternal and child health nursing for 30 applicants, who will be distributed to health centers in Nampula—particularly the most remote ones—when they finish their training.
- Providing financial and logistical support for 324 trainees (86 percent of the target established for the period) who are taking courses in integrated management of childhood illness (IMCI), emergency obstetric care and newborn care, malaria protocols, family planning (FP) logistics, and nutrition package and cold-chain maintenance.
- Hiring five MCH nurses and integrating them with Nampula's official health delivery system.
- Financially and logistically supporting PHD/DHDs for measles, vitamin A, and national immunization campaigns and health days, as well as providing support for mobile brigades by occasionally providing vaccines, contraceptives, vitamin A, and other drugs to remote health facilities to avoid stock outages. Although training of nurses has been supported and nurses hired, quality assurance activities at the facility level have not yet started.

There are particular issues regarding interventions at the institutional level. Some members of both the PHA and DHA perceive their staffs' low managerial skills as key factors contributing to poor monitoring and evaluation of data and poor maintenance of the provincial health management information system (HMIS). Although health workers' training includes some notion of data collection and management, these skills are still very deficient at health facility and district levels. Basic analysis and interpretation of findings and their use for decisionmaking are almost non-existent. Service utilization data are compared with last year's, but only for reporting purposes.

Also, districts have difficulties in reporting data adequately to the province. Although districts received desktop computers, most do not have adequately prepared officers to aggregate and treat raw data. "We need management training at all levels," said a highly placed official in the Department of Provincial Planning and Coordination. "We really don't know how to treat data adequately," said a district officer. Nevertheless, the project and the PHA feel that presentations and reporting of districts at the central quarterly meetings has been improving gradually.

Little, if any, immediate action is taken on findings. Most data and information received at the provincial level are not disaggregated enough to allow adequate decisionmaking to improve service utilization rates and population health status. Also, because of the high turnover of district directors and officers in the province, acquired knowledge is difficult to retain within an office.

Selected activities performed by OKUMI at the community level have included the following:

- Training 42 OKUMI staff—mostly from Nampula—in community mobilization techniques and health-related topics.
- Identifying 373 communities—73 percent of the 2006 target of 432—and mobilizing community leaders, followed by organization of CLCs.
- Identifying 632 volunteers in the community and training 287 in community IMCI (85 percent of midterm target); 189 were trained in vitamin A distribution, and 319 were trained in RH and FP (95 percent of midterm target).
- Training 26 traditional birth attendants in early referral and recognition of warning signs/early transfer/
- Providing IEC material and manuals to 632 community health workers trained in promoting CH/RH services.
- Improving referral systems from the community to the health units through the distribution of 120 bicycle ambulances to communities and implementation of the use of MOH forms to be used in the referral process. Communities implemented a petty cash mechanism for the maintenance of bicycles and bicycle ambulances. The number of referrals to the health facility by the ACS and CLC using the referral forms has been increasing, and at midterm amounted to 13,409 children and 6,512 pregnant women.
- Community health agents (CHAs) have distributed 64,935 oral contraceptive cycles, 88,343 condoms, and 17,704 vitamin A pills, and they sold 17,900 ITNs. (ITNs are directly acquired from PSI by Project OKUMI and sold in the communities by volunteers for about US\$1.20).

In most communities visited, mothers told the team that they would utilize health facilities for delivery if they were not so distant. Most mothers knew about FP, and some were using a modern method. “The injection” seems to be the preferred method. The bicycle ambulance was seen as a big success: “Just the other day, it took this woman to the hospital. The delivery was stuck, and God knows what could have happened...”

Communities were also satisfied with the availability of ITNs for 30,000 meticals, and they indicated that they would appreciate it if OKUMI made more available for the same price: “We cannot afford to buy the ones at the store—but they are very good for us because they keep the mosquitoes away; they don’t let us sleep!”

Because of the delay in project startup, the main activities at the community level began less than 10 months previous, and most volunteers were trained only in the last two quarters. Therefore—and as evidence of progress in behaviour change—the evaluation team investigated the perceptions of health providers and community members. Most health providers interviewed do not perceive any difference in the health knowledge of people who come to the health facility. Generally, there was no perception of an improved link between the health provider and community members.

### **Program and Management**

Although project management has improved markedly following the hiring of a new project manager, lack of staff at managerial and supervisory levels, and particularly at the district level, has impinged negatively on the project’s measurable results and its role in improving the management capacity of district health departments.

The project has very limited staff (two community mobilizers and one supervisor per district) to cover 14 districts and communities spread over 60,000 square kilometers. OKUMI has only four people at the managerial level in Nampula, including the project manager, and there are no

midlevel or lower level managerial staff at the districts to control, supervise, and coordinate field activities. The number of staff is highly insufficient to adequately implement the project, participate meaningfully in the monthly meetings with the DHD, and oversee the collection and treatment of data for both reporting and management.

To conduct its activities, OKUMI has spent 49 percent of its initial budget. Activities conducted, results achieved, and evidence on progress are all well documented.

Not only does OKUMI staff maintain very good relationships with provincial and district health officials, but the project is also being requested by the PHD to participate in MOH strategic planning activities for the next three years. The relationship with USAID is good, and the project makes an effort to follow up on recommendations made during USAID visits.

## **PROJECT LISSIMA**

### **Technical**

Project Lissima is being implemented by the grantee Project HOPE and subgrantee Save the Children USA.

The project's activities concentrate on logistical and material support to PHDs and DHDs, specifically in the CS and RH areas. Although technical support was proposed for the CA, its implementation generally has not occurred.

Project Lissima has spent 30 percent of its total budget. Overall, it has achieved results below its targets, in relation to both its objectives and planned activities. In general terms, while activities at the community level have been implemented and achieved some meaningful results, institutional-level activities relating to capacity building and quality assurance have produced limited results. Evidence of progress is not well documented, and too much reliance is placed on the provincial monitoring and evaluation system.

Project Lissima is perceived by the local health authorities as a valuable asset to the province, effectively complementing its resources, particularly financial ones and resources needed to increase the population's knowledge and awareness of relevant health issues.

Selected activities performed by Project Lissima at the institutional level have included the following:

- Financially and logistically supporting the training of district health facility workers: 45 MCH nurses were trained in IMCI/RH and malaria treatment protocols; 29 MCH nurses were trained in FP and the management of contraceptives; 27 nurses were trained in management of EPI; and nine trainers were prepared. SMI staff also received in-service training in updating data collection and reporting. The courses, which used MOH manuals and tutors from governmental structures, were organized and administered by the project for the MCH nurses appointed by the PHD.
- Supporting the assessment of nine maternities by DHD staff.
- Supporting one vaccination campaign in Xai-Xai city.
- Providing support to 325 (87 percent of planned) district mobile brigades. This support has been not only logistical and financial; it also entails the active collaboration of Lissima's staff in introductory I&E activities (talks) and their direct participation in the delivery of health services such as vaccination and weighing of children and mothers. Lissima's staff also informs communities about the arrival of the mobile brigades and motivates them to attend.
- Occasionally transporting vaccines, contraceptives, vitamin A, and other drugs to remote health facilities to avoid stock outages.

Although refresher training was provided to nurses, quality assurance activities have not yet been conducted. There were stock outs of contraceptives, and the cold chain was out of order on several occasions in various health facilities during the last six months. Also, in the facilities visited, there were very few IEC materials: only a few had essential obstetrical care manuals and none had RH/FP manuals.

The evaluation team noted particular issues regarding interventions at the institutional level. In-service updating of staff in data collection, basic analysis, and reporting is producing some effects—if not yet measurable, they were at least felt by the PHA and witnessed by the evaluation team. In all referral health facilities visited, the MCH nurse-in-charge was somewhat knowledgeable about service utilization, and many diagrams and graphs had been made.

Some health facilities show an acquired interest in obtaining information and feedback on their efforts in tracking numbers of patients. This is probably due to a more consistent approach to the monitoring of services provided. Not only was in-service training provided, but staff members have opportunities to show the results of their work in monthly meetings with the DHA. In addition, Lissima's staff acts as a reinforcer, since they visit the referral centers at least once a month and request some service utilization data for their records. Although there is a long way to go before the monitoring system is adequate, data are reliable and decisions are made on findings. Overall, provincial monitoring systems are improving, and Lissima is contributing to this improvement.

Selected activities by Project Lissima at the community level have included the following:

- identifying 460 communities as direct targets in six districts (51 percent have CLCs organized)
- training a total of 577 volunteer CHAs: 214 volunteers in IMCI (39 percent of midterm target), 196 in RH (79 percent of midterm target), and 167 in epidemiologic surveillance and data collection and analysis (57 percent of midterm target)
- training for 130 traditional birth attendants in maternal and child “danger signs,” training for 30 traditional healers, and training in IMCI for 77 elementary polyvalent agents (21 percent of target).
- Distributed 200 bicycles to CLCs to allow for CHA visits to more distant households.

In most communities visited, the population sang songs with health themes that had been taught by volunteers. The evaluation team saw volunteers preparing and distributing enriched baby foods, and mothers told the team that their babies are “plump and healthy” as a result of their recently acquired knowledge of how to feed them. Many mothers had visited the health facility with their babies, and the others told the team that they would have done so if it had not been so distant. Most of the mothers knew about FP, and many were using a modern method. “I like the injection better, but now I’m using the pill. When I don’t have it, there is no *nothing* (sex)!” said a young woman with a baby in her arms, while the whole group of young mothers laughed.

The team noted particular issues regarding interventions at the community level. Because of the startup delay, there is still little perceived involvement of CLCs in improving the health status of their communities. Linkages with health facilities are yet not relevant, and most health providers interviewed do not perceive any difference in the health knowledge of the people who come to the health facility.

### **Program and Management**

Project Lissima's managerial staff lack appropriate experience, including knowledge of data-based decisionmaking, and there has been no specific in-house training to mitigate this deficiency. In addition, the project is highly centralized, and the program manager has no opportunity to make decisions or take initiatives. The limited managerial capability of Lissima's

staff impinges negatively on the project's measurable results, as well as on the role that it could have in improving management capacity at the district level. Also, the two organizations implementing the project have different management mechanisms, bringing an additional burden to project management.

Project Lissima is perceived by local health authorities as a valuable asset to the province and complementing its resources. As with the other three projects, Lissima has provided needed direct financial support to the provincial health system to conduct outreach activities and train health providers, among other activities. Lissima also has used its own human resources to increase knowledge and awareness of relevant health issues, fulfilling a need that the provincial health system does not have the capacity to meet. The effort has ultimately led to an increase in the use of services.

Targets and results expected relating to the enhancement of quality of care are dependent on technical human resources available at the provincial level to provide refresher-training courses and formative supervision. The lack of human resources is, to a large extent, outside the influence of Lissima, at least in the short term. Moreover, several district directors and provincial directors have been replaced since the CA was signed. New directors needed additional time to understand and endorse the Lissima project.

There is room for improving communications between the project and USAID about the relationship between the project's activities and those of the PHA and DHA. The need for continuous planning and approval of all activities by both the PHAs and DHAs bring additional burdens to the implementation flow, mainly because many meetings are cancelled, PHA priorities change, and district and provincial directors are replaced.

The project's strong centralization and the absence of managerial expertise and ownership contribute heavily to a lack of coordination and control of activities, resulting in lower project performance and execution. Other consequences of these factors are disengagement from project objectives and difficulty in responding to problems or new, shifting situations.

## **PROJECT COACH**

### **Technical**

Project COACH is being implemented by the grantee World Vision Inc. and sub-grantees Johns Hopkins University's Center for Communication Programs, Adventist Development and Relief Agency, and Development Aid from People to People.

During its first year, time was spent hiring the project team; planning first-year activities; completing the baseline survey; consolidating the monitoring, evaluation, and feedback system, and the inception of COACH at district and provincial levels; and coordinating with district and provincial agencies. Special attention was given to building the capacity of the PHD to respond to epidemics of malaria and cholera. World Vision received an additional sum of \$25,000 from USAID to support DHD response to cholera outbreak in Quelimane City and Mocuba District.

Overall, the project has achieved results, and it is increasing its pace toward target objectives and planned activities. Activities at the community level have been consistently implemented in target areas in 14 districts and achieved meaningful results. The integration of the four project partners has led to synergies of effort. World Vision had worked with eight of the 14 target districts under Health Services Delivery and Support (HSDS), a USAID-funded project, on community and facility-based health as well as quality improvement activities. The COACH project was developed to consolidate activities in the original district and expand activities into six more target districts.

Project COACH works well in supporting provincial and districts health needs. An operational plan for the project was developed with all partners, including senior health staff at district and provincial levels. The plan is jointly reviewed quarterly, and adjustments are made.

Although most health providers interviewed already perceive some improvements in community knowledge, much more constant and consistent effort is needed to promote and ensure envisioned health-behavior change. Theater and radio have been extensively used to disseminate health messages, and communities develop this content to incite behavior change within their own cultural and social environments. Also related to IEC activities, interpersonal communication and counseling were introduced in all courses for health professionals and volunteers—a positive and praised initiative.

The increased number of appropriate referrals to health facilities and of mobile brigades camps that provide care at remote zones indicates the project's potential impact in MCH improvement. COACH promotes antenatal and postnatal care for pregnant women and, especially, the involvement of men. About 50 percent of pregnant women attending antenatal care did so in the company of their partners.

In spite of progress made, data monitoring and analysis at the district level need to be improved, and the transformation of data into information remains insufficient.

Selected achievements of Project COACH at the institutional level include

- creating and consolidating an integrated management structure at 14 districts and peripheral health units
- signing a MoU with PHD on planning and implementing activities
- holding monthly meetings at health units and the district level to analyze data and plan activities
- conducting quarterly provincial and district monitoring, evaluation, and planning meetings
- providing courses, in coordination with PHD, for 1,284 health personnel trainees to improve quality and coverage at health system facilities<sup>4</sup>
- supporting DHD outreach activities under the guidance of PHAs and DHAs and co-planning with them for 4,475 mobile brigades/camps in remote areas, immunization campaigns, and work related to cholera outbreak
- buying the 14 cars and 30 motorcycles distributed among the 14 districts

In addition, 126 health units are implementing IMCI strategy, 63 health units are implementing QA methodology, and 12 district staff (eight representatives per district) participate in exchange visits.

The following issues affect interventions at the institutional level. The huge size of Zambézia province; the distances between communities, health centers, and district headquarters; bad road conditions; and widely dispersed population make access to health facilities difficult and impede more visits from mobile brigades to communities. In addition, the poor condition of many health centers, the perceived poor motivation of some health professionals, and the lack of transportation and communication between health units at different levels also constrained the attainment of the expected project midterm results, particularly those relating to improved linkages between communities, health facilities, and health professionals.

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<sup>4</sup> Courses included quality assurance cycle (QA), interpersonal communication and counseling (ICC), IMCI, compulsory notifications diseases, FP, HIS, community health information system, basic epidemiology, IMCI and RH training of trainers, district management, and training of trainers for theater actors and those working in community radio. Procedures standardization was also developed. ICC was included as one topic for all provincial training courses.

Selected activities performed by the COACH project at the community level included the following:

- Establishing 217 new community health councils (CHCs) (98 percent of total project target); a total of 467 CHCs are now organized. Of these, 365 (78 percent) prepared annual action plans, based on their prioritized solutions for health problems, and 340 (73 percent) have emergency preparedness and prevention plans. During its first year, each new CHC received a supervisory visit every 40 days. Quarterly visits are subsequently planned to provide support in mapping their village, discuss health plans, and motivate centers to be active in illness prevention, health promotion, and good health practices implementation. Besides performing direct health activities, all CHCs visited by the evaluation team are building toilets, “bathrooms,” plate racks, and rubbish pits, and these efforts are encouraged and facilitated by COACH.
- Training 5,454 community health volunteers, as well as forming 190 mothers’ groups and training them to identify and address priority health needs in their communities. The mothers’ groups worked with 5,852 families on renourishing growth-faltering and at-risk children, FP, and other RH issues. Several health education sessions were conducted by CHAs.
- Training theater actors and radio speakers to disseminate educative messages; 2164 dramas were conducted, and 267 radio programmers aired.
- Training traditional healers and other volunteers. Traditional birth attendants (TBAs) are referring pregnant women to institutional births.
- Distributing 200 bicycle ambulances to CHCs (91 percent of total project target) that have transported 6,197 pregnant women and 7,271 children under 5. About 76 percent of CHCs now have functional cost-recovery schemes for their bicycle ambulances.
- Selling 1,287 ITNs in a pilot project in the Pebane and Chinde districts. In addition, 13,713 Certeza bottles were purchased by communities.
- Contracting 70 tutors (five for each district) in reading and writing. The 756 women who received literacy education were enabled to read and write; improve their quality of life by educating them on good health and nutrition practices, FP, and HIV/AIDS/STI; and participate fully in local development processes.

The following are particular issues relating to interventions at the community level:

A community health information system is in place, with simple forms that use drawings instead of words. Each month, a CHC representative goes to its health facility to deliver data sheets and discuss problems and solutions with health professionals and project district staff. Besides health-related activities, COACH is supporting the education of women.

Communities members interviewed indicated that the number of malnourished children had decreased and that women were going more frequently to health facilities for prenatal care and childbirth, in the company of their partners. Furthermore, many personal habits had changed, such as washing hands and boiling water. Community members also talked about sexuality and reproductive health more openly, and they feel well received by health professionals at health facilities. “Everything is better now,” said one woman. One of the probable results of the many CHC initiatives is that the Mocuba district was not affected by cholera outbreak in 2006.

The increased number of appropriate referrals to health facilities and mobile brigades/camps that provide care at remote zones indicates a probable positive impact of the project on MCH.

Despite COACH’ s effort to encourage women’s participation in training, men still constitute the majority of attendees. The project will continue efforts to empower women to take responsibilities and make decisions regarding health problems in their communities.

## **Program and Management**

Project COACH has adequate leadership and management. The four different organizations work together cohesively, and relationships in technical, administrative, and financial areas are excellent. The project's large number of field-level managerial staff and its decentralized and horizontal structure allow for adequate implementation of field activities and interaction with both provincial and district health officials.

World Vision maintains costs at appropriate levels. The NGO expended 48 percent of the total project USAID budget and achieved more than expected for the period in several areas. Expenses are carefully estimated, and some costs are analyzed.

According to Zambézia PHD, "COACH Project impact is a very positive one; most important is the community empowerment in order to deal with their health issues. The CHC is the link with the health system, and it is the people's voice."

Project COACH works closely with PSI in the selling and distribution of ITNs and Certeza , which have had a larger demand than supply.

## **PROJECT MANHIÇA, PATHFINDERS**

### **Technical**

Project Manhiça is being implemented by Pathfinder International. In contrast to the other three projects, Project Manhiça's original proposal focused more on the improvement of quality of healthcare at the institutional level than on community direct interventions. However, the workplan was revised—by mutual agreement of local authorities and USAID—to shift the main focus to the community level.

The project's primary objectives are to: 1) link communities with health services in Manhiça district, Maputo province 2) facilitate the delivery of quality MCH/RH interventions within communities in the district; 3) promote and support key health behaviors and practices at community and household levels; 4) improve the quality of priority MCH/RH service delivery within health centers and health posts in the district; and 5) improve overall management of public-sector service delivery at health unit, district, and provincial levels.

Overall, the project achieved most of its planned results, and it is increasing the pace of implementation. Activities at the community level have been consistently implemented in one of the three geographic target areas of Manhiça district. It can be anticipated that interventions in other areas will be faster, due to the experience acquired.

Project Manhiça works well in supporting provincial health needs, and this contributes to its objectives and goals. The project's operational plan was developed with senior health staff at district and provincial levels; it is jointly reviewed on quarterly basis and adjustments made. The project complements the resources of the formal health system with respect to facilities improvement, health personnel training and supervision, and—most significantly—community-level activities and participation.

Selected activities performed by the Project Manhiça at the institutional level have included the following:

- conducting, analyzing, and publishing a KAP (knowledge, attitude, and practice) study on MCH and FP, in partnership with Centro de Investigação em Saúde de Manhiça
- performing an assessment of all health facilities in Manhiça district
- collaborating on the design of community mapping with DHD and other government authorities

- developing a definition of health-service quality standards as well as a supervision guide that is in use
- rehabilitating two health centers and one pre-delivery house
- reactivating two youth rooms
- installing six solar-powered systems to provide power to health facilities and for vaccine cold chain.
- installing oral rehydration corners
- establishing a good link between health facilities and communities
- financially and logistically supporting the training of 224 health professionals in IMCI, emergency obstetric care, Prevention of Maternal To Child Transmission , TCP, Volunteer Counseling and Testing, IPT, formative integrated supervision, Maternal Child Health norms, biosafety, FP logistics, quality assurance cycle, and community involvement and monitoring
- extending the training of health professionals to the province (108 participants from Manhica district and 116 from other districts in Maputo)
- participating with MOH in 30 joint supervision visits of project and DHD staff to health centers
- supporting 129 mobiles brigades
- co-designing a two-year training plan with PHD and DHD
- revising and establishing a performance monitoring and evaluation plan
- supporting
  - measles vaccination for 9 months to 14 years (42 percent of district population)
  - polio vaccination at 0–59 months (17 percent of district population)
  - vitamin A distribution at 6–9 months (15 percent of district population)
  - national measles and polio vaccination campaigns, including vitamin A distribution

Select activities performed by Project Manhica at the community level included the following:

- Developing different strategies to constitute CLCs for rural areas (traditional leaders) and urban areas (government social structure).
- Developing and implementing a community health information system, including referral forms.
- Establishing 32 community leadership councils for health (CLCHs)—100 percent of target—all with CHAs. Of these, 65 percent are analyzing community-Health Information System (C-HIS) to find solutions to health problems and 35 percent (11) of CLCHs are developing plans based on prioritized solutions to health problems in their respective communities.
- Training 409 CHAs (84 percent of target) in community IMCI and RH community-based distribution. The CHAs conducted 3,462 registered home visits, and they are systemically supervised by 59 SUFORS (supervisors/trainers) who have each received a four-week training course.
- Acquiring and donating 36 cows and 45 goats to five CLCHs that represent 20 communities. This is a unique activity that will help communities in plowing plantations, transporting sick

persons to health centers, and, perhaps, starting small businesses that raise funds for community health and economic activities.

- Supporting the airing of health messages and interviews in 77 community radio programs (66 percent of target), and successfully conducting “health debates,” initially for specific audiences (according to sex, age, activity), which now engage mixed audiences.

Results include 261 children under 5 referred by CLCHs and CHAs to health centers for treatment (74.5 percent of midterm target); referrals by TBAs of 60 pregnant women to health center for delivery (45.8 percent of midterm target), and 3,462 registered home visits by CHAs, who collected data reported in community HIS forms.

Activities conducted and results are well documented, and outputs reported are consistent. In addition, evidence on progress, monitoring, analysis, and interpretation of data and information are shared, discussed, and analyzed with district and provincial staff.

The following issues relate to interventions at the community level. Because the project includes peri-urban and rural communities, differing mobilizing and organizing strategies were developed. In the same vein, specific strategies were developed to conduct health debates with particular groups—by sex, age, activity—but now the project can bring together these different groups to participate actively in debates.

The communities visited were deeply involved with health issues. They reported that many of their personal habits had changed, such as washing hands and boiling water. Community residents also reported that they talk more freely about sexuality and RH, and women are increasingly going to health facilities for prenatal care and childbirth.

Initially, community residents had difficulty in understanding the rationale of project activities. Now CLCHs understand their role, talk with people about health and prevention, and meet with CHAs and support their work. The Palmeira CLCH (in an urban area) established schedules so that someone is at the health center every day to ensure that community members are well treated by health professionals.

### **Program and Management**

Project Manhiça has strong leadership and adequate managerial skills. Its structure is appropriate for project implementation and its involvement with the MOH to enhance quality of care. In fact, not only does the project have a much higher proportion of managerial staff to targeted population than other projects evaluated, but its staff is highly qualified and experienced in MOH processes and procedures.

Project Manhiça has pursued its expected results with creative and innovative approaches, and these should be considered as a model for sustainable community development and health system integration. The methodology was carefully and thoroughly developed, activities were conducted and results achieved, and evidence on progress was well documented and routinely shared, discussed, and analyzed with district and provincial staff.

### III. CONCLUSIONS

#### LESSONS LEARNED

The following lessons may be drawn from the midterm evaluation findings.

##### **Project Design and Approach**

The present approach to project implementation includes both practices that are both promising and challenging:

- Working through and with the formal health official structures at district and provincial levels is a commendable and appropriate approach that
  - promotes and facilitates sustainable development of both institutions and communities
  - reinforces government efforts to improve and strengthen official structures, processes, and procedures
  - allows for an appropriate complement of local government resources and infrastructures, particularly in terms of community interventions
  - increases the government's appreciation of the value of PVOs in implementing projects of this nature
- Conversely, the approach
  - implies additional human, time, and financial resources that eventually decrease its cost-effectiveness
  - resulted in delay in the start of project activities and non-achievement of some behavior-change-related targets
  - makes it very difficult for projects to comply with timelines and reporting obligations

A different mechanism to project implementation that addresses this duality needs to be developed.

##### **Project Monitoring and Evaluation**

Short-life projects focused on community development in limited geographical areas are inappropriate for achieving population-based targets— such as increased use of CS and RH services—that are measured for the entire district.

##### **Interventions at the National Level**

The approach and interventions designed and implemented to improve health delivery services need to be strongly coordinated and interlinked, and they should pursue a consistent and comprehensive approach to quality of care. Inconsistent and narrow-focused interventions will have limited and short-lived effects.

##### **Interventions at the Community Level**

- Monthly discussions that include the community, health facility, and district directorate emphasize the importance of the analysis of community HIS and result in actions to improve community health status.
- Community volunteers have difficulty in correctly filling out referral and activity forms.
- Male involvement facilitates the removal of barriers to FP and prenatal care.
- Improved linkages between the population and the formal health system need to be promoted through simultaneous actions at both levels.

- Empowering communities to find solutions to their health problems requires a series of behavior-change processes and steps that are sequential; time should be allowed for desired changes to be internalized.

### **Organization's Leadership, Management, Structure, and Culture**

Projects results depend on

- the level of leadership and appropriate management experience and expertise at each and all levels
- the adequacy of the project's organizational structure, particularly the availability of adequate human resources in the different target districts
- the length of time the NGO has been working in the communities, districts, and province, and the strength of personal relationships at these different levels
- the adequacy of interpersonal communication skills.

## **RECOMMENDATIONS**

General recommendations include the following:

Develop alternative implementing mechanisms and approaches to achieve the approved SO8 results in the remaining project life.

There should be no drastic changes in the implementing mechanisms and project approach, nor any changes that negatively affect the present progress of the projects. However, changes in the focus of selected activities and priorities—including an increased focus in the delivery of health services to remote populations—are appropriate for all projects if they are to contribute significantly to the USAID/Mozambique SO8. To improve the use of project resources and their cost-effectiveness, some changes in the monitoring format of the projects and their end-life evaluation need to be addressed.

### Project monitoring and evaluation

For the management of the project, the CA should refocus the monitoring and evaluation system on collecting and using project-activity-level data, instead of population data. Population data are not appropriate for monitoring CA activity because changes in these data require lengthy implementation as well as an array of interventions (only some of which are being implemented by the CAs).

### Interventions at the National Level

- To design and implement coordinated, comprehensive, and consistent interventions aiming to assure quality of care,
  - adapt or develop with MOH officials mechanisms and tools for health facility assessment and formative supervision, including quality of care standards and assurance method, through Project Forte Saúde and in conjunction with other projects and NGOs working in the same technical areas
  - provide technical, financial, and logistical support for expeditious efforts to revitalize provincial supervisory teams and ensuing supervisory activities.
  - provide logistical and procedural support to the maintenance of buildings and equipment and efforts to make available adequate stocks of essential drugs, vaccines, contraceptives, and consumables
  - provide logistical and procedural support to make available IEC materials and technical manuals and protocols at health facilities

- To design and implement coordinated activities aiming at the rapid and significant increase of the use of CS and RH services,
  - increase logistical and financial support to mobile brigades that cover remote communities.
  - support planning of outreach activities so that communities are visited by mobile brigades at least once a month
  - ensure communities and CLCs are aware of the mobile brigade' s arrival and use its services adequately
  - increase levels of community-based distribution and referrals to health facilities, developing linkages between community health workers and CLCs and the staff of mobile brigades
  - promote heavily the use of *casas da gestante* (pre-delivery houses at hospitals)
- To co-design and implement activities aimed at the building the capacity of district directorates in strategic planning and data collection and treatment,
  - ensure the project has adequately trained and expert staff at the district level to provide skills transfer at every contact
  - assess perceived needs and preferences, and offer service-training or formal, short, management-related courses that meet these needs and preferences

#### Interventions at the Community Level

All projects should:

- Continue to design and implement activities that lead to community empowerment and community involvement in the development of partner-defined quality of care.
- Increase efforts to promote monthly discussions between representatives of the community, the nearest health facility, and the district directorate to analyze findings of community HIS, promote necessary linkages, and design next steps. As much as possible, men and women should be represented in these different groups.
- Encourage, promote, and facilitate the development of integrated, multisectoral, community-based synergistic activities, particularly activities that are agricultural, entrepreneurial, or educative.
- Given the importance of access to clean and safe water, promote and assist CLCs in water and sanitation activities.
- Increase the level of non-financial incentives to motivate volunteers.

#### Organization' s Leadership, Management, Structure, and Culture

- Assess information needs and adjust information systems to better collect, manage, and use relevant data for decisionmaking at all levels.
- Assess training needs at all levels, and provide appropriate in-house training to improve the collection, management, and use of relevant data in the decisionmaking process.
- Develop and implement user-friendly tools that adequately assess activity costs, since it is too late to implement a specific activity-based costing system.

#### **Project OKUMI**

To implement the above recommendations, attain most of the results expected, and contribute effectively to the USAID SO, OKUMI needs to restructure and increase substantially its presence in the districts. Because of budget constraints, this will require improving the management capacity of current staff. At present, management skills are more needed than technical skills.

Control will need to be tight and coordination of activities strong. Coordinators will probably not be experienced, since experienced human resources are scarce in Nampula province. In-house management training and continuous supervision will thus have to be provided.

### **Project Lissima**

For Lissima to implement the above recommendations, attain most of the results expected, and contribute effectively to the USAID SO, the project should act rapidly to meet the following *sine qua non* conditions:

- management improvement
- clear definition and understanding of the intended relationship between Lissima and local health authorities
- training of staff in the management of data and its use in the decisionmaking process

In addition, Lissima needs to

- investigate the degree of demographic changes in Gaza that might affect project indicators
- review project targets in terms of the actual situation at the community level and demographic changes found

### **Project COACH**

- Expand the ongoing experiences of integrated, multisectoral, community-based activities, including income-generating activities.
- Document lessons learned to enable other projects to replicate appropriate approaches and implementing mechanisms.

### **Project Manhiça**

Expand the project for other areas within Manhiça district, and later expand to other districts from Maputo province.

## IV. FUTURE DIRECTIONS

Although USAID does not contribute to the SWAp pool of funds, its present collaboration with the Mozambican Government and other donors is perceived as relevant, welcomed, and “SWAp-sensitive.” Through joint planning, USAID and the Mozambican Government should strive to closely align future project activities with the government’s strategic plans to better synchronize allocation of available and required human and financial resources. Following synchronization of planned activities, NGOs should implement their projects in accordance with provincial activities without disrupting existing processes.

NGOs are seen by Government of Mozambique and donors as a valuable asset in the present context. NGO activities complement governmental resources, and the organizations have a community development focus that would otherwise be absent.

Future planning for USAID health activities in Mozambique should be cognizant of other donor-supported models being employed to address the challenges in moving away from health systems that are largely planned and governed by technical personnel to ones that involve wider public participation and accountability in planning, implementing, and monitoring health services. Such new models should consider factors that contribute to motivation for changes in approach and toward a greater degree of community participation in mechanisms for the governance of health service delivery.

Specific issues to consider in design or redesign of USAID health activities in Mozambique include

- consumer demand for improved quality services
- ways to approach the need to ensure greater impact in resource use
- changing roles suggested by health policy reforms and in relation to processes of decentralization
- health service motivations to widen resource mobilization strategies and, particularly, community contributions to health
- perceptions of civic groups, elected and traditional leaders, and health service providers about how community participation should be restructured

Several promising methodologies are being used to integrate institutional and community involvement in improving access to quality health services and maximizing resources and community assets. These include assets-based development; client-oriented, provider-efficient services (COPE); and participatory learning and action (PLA).

- **Assets-based development:** This method depends on mapping community assets, rather than deficiencies, and it builds on these assets. The underlying rationale is that (1) significant community development takes place only when local people are committed to investing themselves and their resources in the effort, and (2) community development is more likely to be sustainable when it develops around community assets, instead of external inputs. Each community has a unique set of assets upon which its development can be built, and asset-based development begins with the construction of a new “map” of such assets. Once this guide to community capacities has replaced the old “map” of community needs and deficiencies, the community can begin to assemble its strengths into new combinations, new structures of opportunity, and new possibilities for development.
- **COPE:** Cope was originally developed for FP clinics in Kenya and Nigeria in 1988, and has since been introduced in 50 countries around the world with proven success. COPE is a relatively simple process for improving quality in health services. It encourages and enables

service providers and other staff at a health facility to assess jointly with their supervisors and clients the services that they provide. Using various tools, they identify problems, find causes, and develop effective solutions. The COPE tools include a series of self-assessments guides, client-interview guides, client-flow analysis, and an action plan. The self-assessment guides and the client interviews help health providers identify problems related to the service-delivery process and develop an action plan to improve the quality of health delivery services.

- PLA: The common theme in PLA approaches is the full participation of people in the processes of learning about their needs and opportunities, as well as in actions required to address them. Participatory approaches offer a creative approach to investigating issues of concern to civil society and a creative approach to planning, implementing, and evaluating development activities. These approaches challenge prevailing biases and preconceptions about local knowledge. Methods in use range from visualization to interviewing and group work. The common theme is the promotion of interactive learning, shared knowledge, and flexible but structured analysis. These methods have proven valuable in a wide range of sectors and situations. Participatory approaches offer opportunities to mobilize local people for joint action. They can also bring together different disciplines—such as agriculture, health, and community development—to enable an integrated vision of development and well-being.

The context in which USAID/Mozambique will be working for the next five years is changing because Mozambique is entering a period of effective decentralization. Starting in January 2007, the district will be the primary implementing unit, with both execution and investment funds allocated directly in amounts that are based on a district budgetary plan. Although vertical governmental structures remain highly relevant, the district will be the unit of development.

To keep up with the changes, reinforce local institutions, and facilitate the decentralization process while achieving the approved SO8 results in the remaining period through September 30, 2010, USAID should adapt its approaches once more. Projects should be consonant with the goals and perceived needs of Mozambique's new, organic, development unit—the district. In addition, to enhance outcomes and cost-efficiency, as much as possible projects should be implemented with a cross-sectoral or multisectoral approach. To promote economic growth and sustainable interventions, partnerships with and the development of the private sector should also be considered. Needless to say, health-related strategies for the whole country and the assessment of overall health priorities remain with the MOH, even after decentralization. However, project implementation design will occur at the district level, which requires focusing on district development as a whole and the involvement of different sectors.

USAID has had a positive experience in other African countries such as Madagascar with integrated, multisectoral approaches to development. Resources are shared, and projects aiming at sustainable development are more effective and cost-efficient. On the other hand, integration demands a different approach from both USAID and implementing PVOs when it comes to project design, monitoring, and evaluation, particularly in the selection of activities that ensure synergism, cross projects, and the sharing of resources.

The present USAID approach of working with and through the provincial and district governmental structures is commendable, since it facilitates sustainable development. However, as seen through this evaluation exercise, it consumes additional human resources. To mitigate this effect when working with and through new organizational structures in districts and within different sectors, PVOs might require a facilitating entity to interface simultaneously with the Mozambique Department of Planning and Local Development at the District Secretariat<sup>5</sup> and one or more PVOs implementing different, synergic, and integrated projects. Discussions about

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<sup>5</sup> Republica de Moçambique, Estatuto Organico da Secretaria Distrital, Artigo 3.

project objectives and main activities are to take place at the central level, before the project is designed and the CA signed. In the new situation, however, the central level is concomitantly the Mozambique Ministry of Health and district authorities.

Future project design should allow for implementing partners' creativity, and should be cognizant of provincial differences. The health facility could become the nucleus of community initiatives and the development of communities in the facility's catchment area. Future design should employ the results of cost-effectiveness studies in models for the implementation of community-based interventions. And finally, projects should continue the harmonization of multisectoral activities that engage donors, the government, and other partners.

## **ANNEX C: PERSONS CONTACTED**

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## ANNEX D

### PROJECT DOCUMENTS REVIEWED

## **ANNEX D: PROJECT DOCUMENTS REVIEWED**

### **MAIN DOCUMENTS CONSULTED**

#### **Project Reports and Relevant Documents**

##### Lissima/Project Hope

- Cooperative Agreement
- Project Hope - March–September 2005
- Project Hope - CSRH Annual Report October 2005 CA 656-00-05-00029-00
- Project Hope - October–December 2005
- Project Hope - January–March 2006
- Project Hope - April–June 2006
- Project Approved Workplan
- for 2006 including Conducted Activities (finalized with the E-team)
- PVO M&E reporting form to the end of September
- Internal accounting files and procedures
- KPC

##### **OKUMI Project/ Save the Children**

- Cooperative Agreement
- OKUMI Project Quarterly Report, April–June 2005
- OKUMI Project Quarterly Report, July–September 2005
- OKUMI Annual Report, April–September 2005
- OKUMI, October–December 2005
- OKUMI, January–March 2006
- OKUMI, April–June 2006
- OKUMI, Annual Report October 2005 –September 2006
- Project Approved Workplan
- Workplan for 2005–2008
- Workplan for 2006
- Workplan for 2006 including Conducted Activities
- PVO M&E reporting form
- Internal accounting files and procedures
- KPC

##### **Increased Use of Child Survival and Reproductive Health Services in Manhiça District – Maputo Province/ Pathfinder International**

- Cooperative Agreement
- Pathfinder, July–September 2005
- Final USAID Fiscal Year Report 2005, Manhiça, Mozambique
- Pathfinder, October–December 2005
- Pathfinder, January–March 2006
- Pathfinder, April–June 2006
- PMPPVO 3<sup>rd</sup> quarter 2<sup>nd</sup> FY – Pathfinder
- PMPPVO 4<sup>th</sup> quarter 2<sup>nd</sup> FY – Pathfinder
- Project Approved Workplan
- Workplan for 2006
- PVO M&E reporting form
- Internal accounting files and procedures

### **COACH Project/ World Vision**

- Cooperative Agreement
- COACH Project Quarterly Report, April–June 2005
- COACH Project Quarterly Report, July–September 2005
- COACH Annual Report 05
- COACH Project Quarterly Report October–December 2005
- COACH Project Quarterly Report January–March 2006
- COACH Project Quarterly Report April–June 2006
- COACH Project Quarterly Report July–September 2006
- COACH Annual Report, October 05 to September 06
- Project Approved Workplan
- Workplan for 2006
- PVO M&E reporting form
- Internal accounting files and procedures

### Related USAID Documents

- APS August 27, 2004

### Republic of Mozambique Legal Documents

- Boletim da Republica, Quarta-feira, 12 de Abril de 2006, I SERIE- Numero 15 (Decentralization Act)
- Boletim da Republica, Segunda-feira, 19 de Maio de 2003, I SERIE- Numero 20 Suplemento (Organization and Functioning of State Organs)

### Related MOH Reports, Documents, and Manuals

- Estratégia de Envolvimento Comunitário, MISAU, Outubro 2004
- PARPA - Plano de Acção para a Redução da Pobreza Absoluta 2006–2009, República de Moçambique, Versão Final de 02 de maio de 200
- PESS - Plano Estratégico do Sector Saúde para 2005–2010; versão setembro de 2006
- Mozambique Demographic and Health Survey 2003; Instituto Nacional de Estatística de Moçambique, Ministério da Saúde de Moçambique com apoio técnico de Measure DHS+/ORC Macro, Agosto 2004
- Quinta Avaliação Conjunta do Sector Saúde, Moçambique, Relatório Final, 2005, MISAU e Parceiros de Cooperação, Abril 2006
- Atenção Integrada às Doenças da Infância, AIDI Simplificado - Guia Técnico, MISAU, Divisão de Saúde e Desenvolvimento Infantil da OMS, UNICEF, USAID, JSI & JHU/ Projecto HSDS, Maio 2002
- Manual de Cuidados Obstétricos Essenciais, 2ª Edição, MISAU, NORAD, UNFPA, Columbia University, USAID/JSI, 2003
- Módulo de Cuidados Maternos para o Facilitador, MISAU/ DPS Maputo/ DDS Manhica/ Saúde da Comunidade, Pathfinder/ USAID. Novembro 2005
- Supervisão e Avaliação da Componente de Saúde Reprodutivo e Recém-nascido - Guião para Supervisão das US periféricas, MISAU/ DPS Maputo/ DDS Manhica/ Saúde da Comunidade, Pathfinder/ USAID.
- Manual de Cuidados Essenciais ao Recém-Nascido, MISAU - Secção de Saúde Infantil - com assessoria técnica de Advance África/ USAID, Agosto 2004
- Tratamento Intermitente Preventivo da Malária na Gravidez - TIP Malária - Instruções para Profissionais de Saúde; MISAU/DNS/DSC/SR/PNCM, Fevereiro 2006

### Related World Bank Reports

- Mozambique Health Country Status Report, World Bank, 2004/2005

#### Other Relevant Reports

- Provincial Study to Evaluate the Approaches to Supporting Health Sector Development at Provincial Level, Final Report, Mozambique 2001–2005
- Analise de Vulnerabilidade Corrente em Tres Provincias de Moçambique. Grupo de Análise de Vulnerabilidade, Secretariado Técnico de Segurança Alimentar, Fevereiro de 2005
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